New Hampshire Medicaid Care Management Quality Performance Report

Key Indicators – December 2014

A Report Prepared by the Medicaid Quality Program
Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services

December 4, 2014

The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence

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Overview

Introduction

The New Hampshire Medicaid Care Management (MCM) Quality Program Performance Report presents key indicators used to monitor MCM. This monthly report presents the most up to date generated and validated data for the MCM program.

The key indicators are organized into topic areas called domains. The key indicators are drawn from measures that are both available now, or will be in the future; placeholders allow users of the report to better understand when indicators become available and to provide a consistent set of information.

The report presents program-wide averages. Additional information is available for all key indicators. Additionally, the Medicaid Quality Program is developing focused reports and a web-based reporting system allowing user directed reports.

Quality Domains

- Access and Use of Care
- Customer Experience of Care
- Provider Service Experience
- Utilization Management
- Grievances and Appeals
- Preventative Care
- Chronic Medical Care
- Behavioral Health Care
- Substance Use Disorder Care
- General

DOMAIN: Access and Use of Care

Introduction

Access and Use of Care includes key indicators in the following areas:

- Provider Network
- Ambulatory Care
- Non-Emergent Medical Transportation
- Inpatient Care

Provider Network

Figure 1-1: Member Request for Assistance Accessing Providers

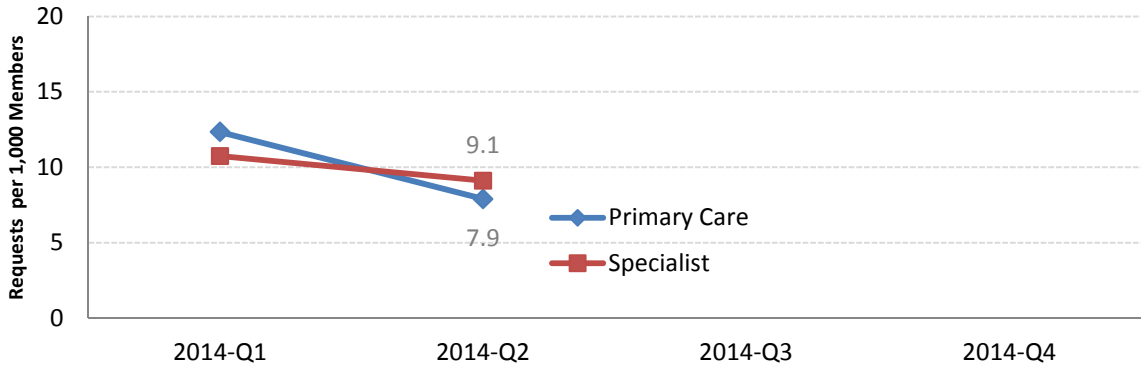
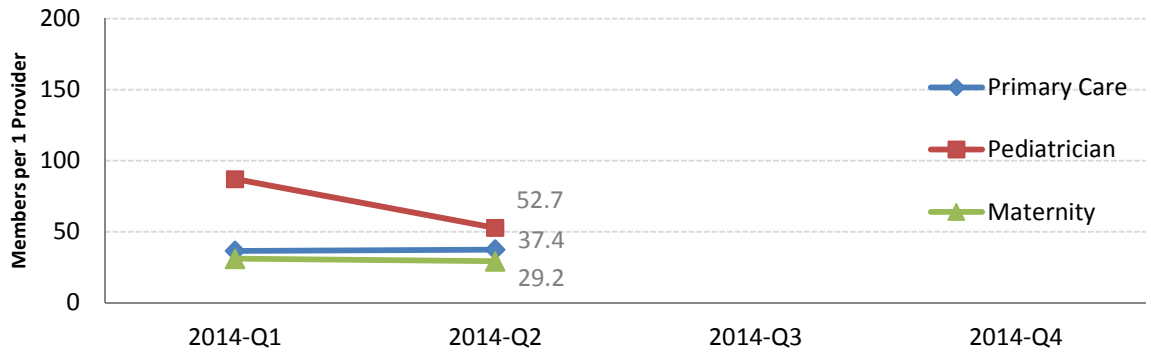


Chart unchanged from last month's report

Description**:** Access to care is an important first step in meeting health care needs. A high volume of calls requesting assistance accessing providers could indicate problems with a provider network. This measure describes members requesting help finding and getting appointments for doctors, divided by the number of members. Multiple requests by a single member are all individually counted in the rate. The rate is shown per 1,000 members. For example, a rate of 11 specialists would indicate that out of every 1,000 members there were 11 individual requests for assistance in accessing a specialist.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Figure 1-2: Member to Provider Ratio



Description: Access to care is an important first step in meeting health care needs. A high or rising ratio of members to providers could indicate an inadequate provider network and could increase member difficulty accessing care. This measure describes the average number of members, divided by the number of primary care doctors, pediatricians, and maternity providers.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

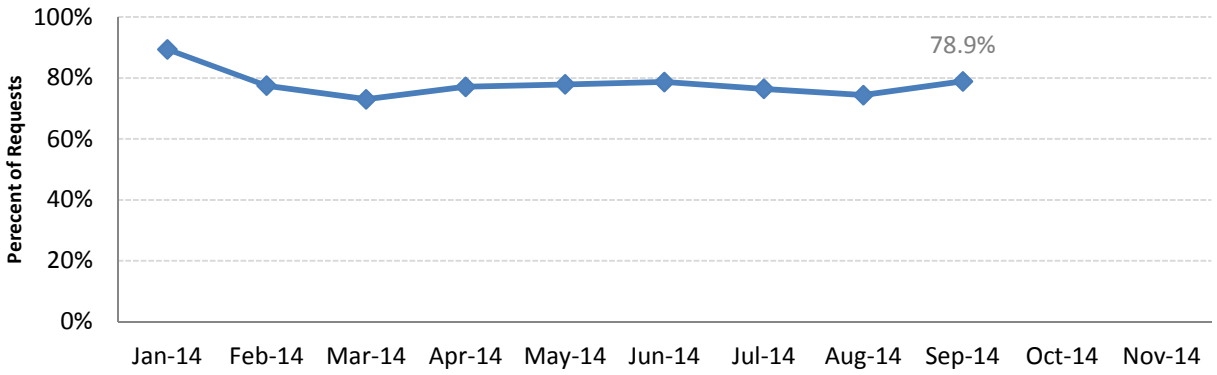
Figure 1-3: Member to Provider Ratio: Substance Abuse Counselors - NHHPP Members

(Available Winter 2015)

Description: Access to care is an important first step in meeting health care needs. A low or falling ratio of members to providers could indicate an inadequate provider network and would increase member difficulty accessing care. This measure describes the average number of members, divided by the number of substance use disorder providers.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

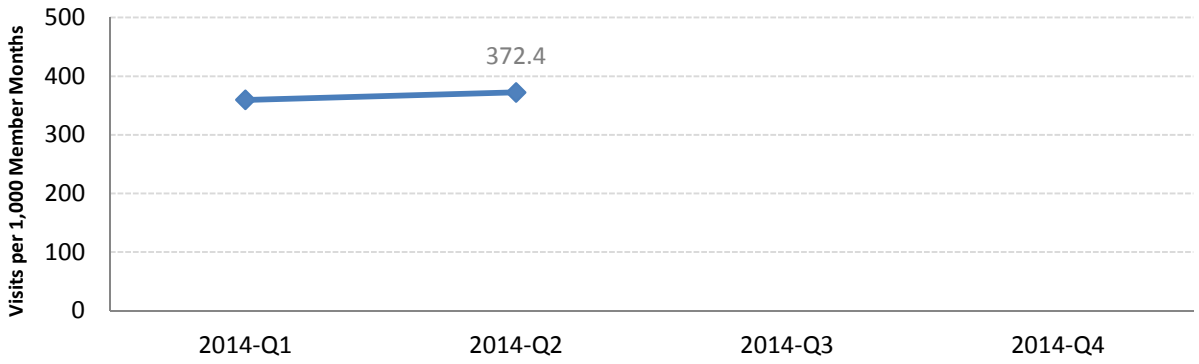
Figure 1-4: Transportation Requests Approved and Delivered



Description: A lack of transportation can be a barrier to accessing health services. A low or falling rate of requests for transportation that have been made, but not approved or delivered could indicate that transportation needs are not being met. This measure describes the number of non-emergent requests for transportation approved and delivered, divided by the total number of non-emergent transportation requests, as a percentage. The types of transportation included in this measure are contracted transportation providers, volunteer drivers, member drivers, public transportation, and other.

Frequency: Reported monthly, available approximately 2 months after end of the quarter.

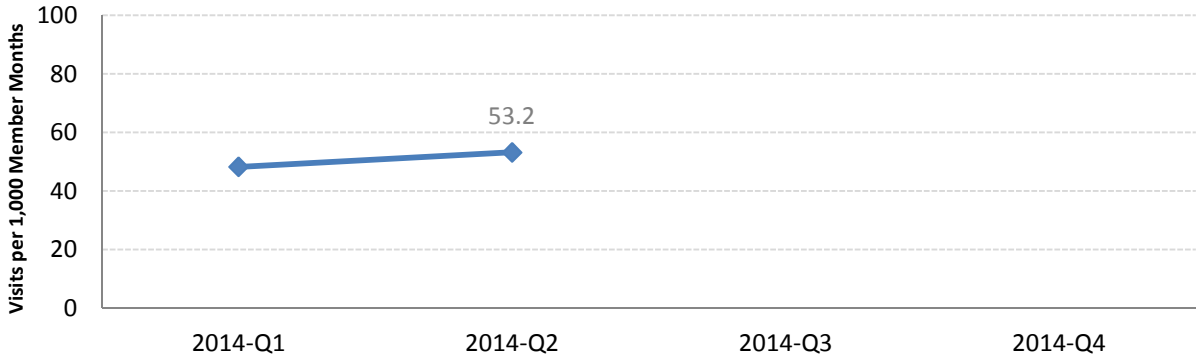
Figure 1-5: Physician and ARNP Clinic Visits



Description: Measuring provider visits is a standard industry approach to better understand the use of ambulatory (outpatient) health services utilization. This measure describes the number of provider office visits, divided by the number of member months. The result is a quarterly rate of visits per 1,000 member months. Member months are a count of how many months each member was in the managed care program. A member who was in for the full quarter would add 3 member months to the total; a member who was in the program for 1 month would add only 1 month to the total. The denominator is divided by 1,000 to calculate a rate that can be more easily compared.

Frequency: Reported quarterly, available approximately 5 months after end of the quarter.

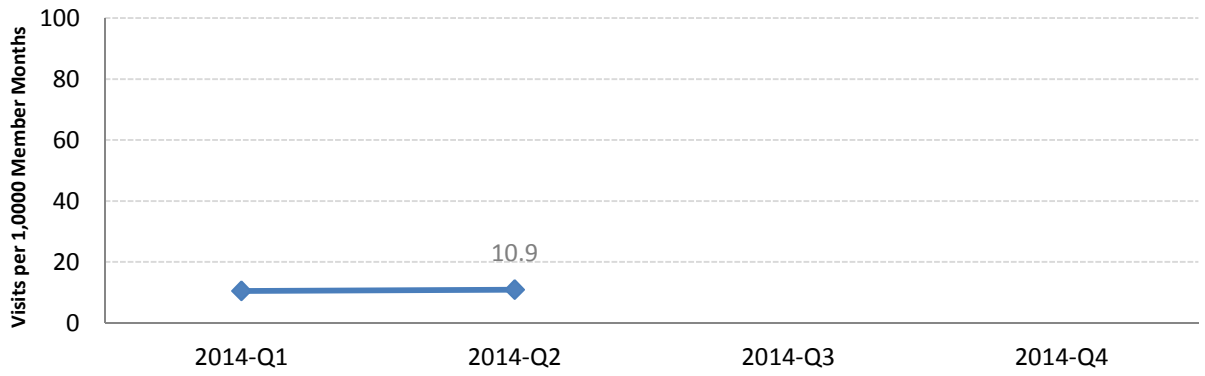
Figure 1-6: Emergency Department Visits



Description: Measuring emergency department visits is a standard industry approach to better understand the use of emergency departments. This measure describes the number of emergency department visits, divided by the number of member months. The result is a quarterly rate of visits per 1,000 member months. Member months are a count of how many months each member was in the managed care program. A member who was in for the full quarter would add 3 member months to the total; a member who was in the program for 1 month would add only 1 month to the total. The denominator is divided by 1,000 to calculate a rate that can be more easily compared.

Frequency: Reported quarterly, available approximately 5 months after end of the quarter.

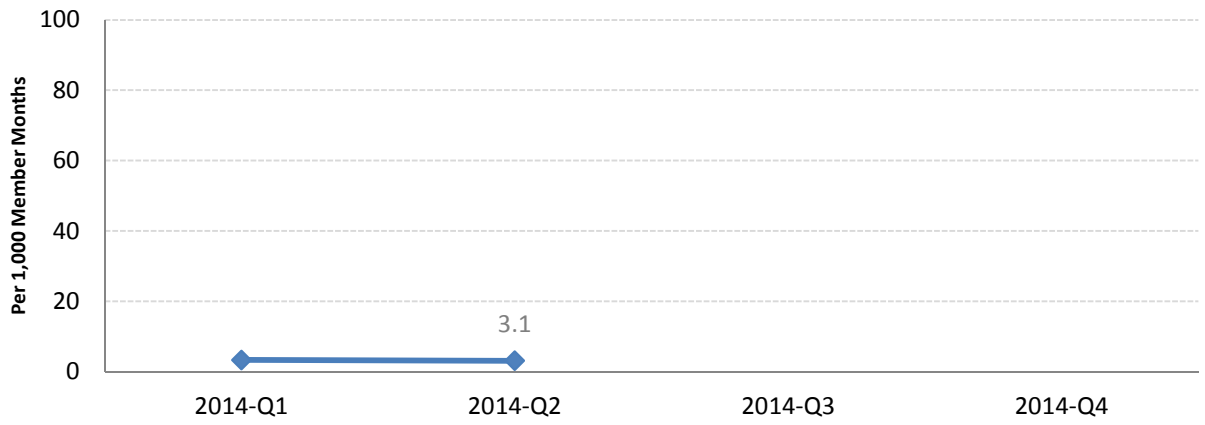
Figure 1-7: Emergency Department Visits Potentially Treatable by Primary Care



Description: The Emergency Department is not the best setting for primary care health services. A high or increasing number of visits could indicate that members are having difficulty accessing primary care services. This measure describes emergency department visits for reasons that might have been managed in a doctor's office (for example, colds, rashes, etc.), divided by the number of member months. The result is a quarterly rate of visits per 1,000 member months. Member months are a count of how many months each member was in the managed care program. A member who was in for the full quarter would add 3 member months to the total; a member who was in the program for 1 month would add only 1 month to the total. The denominator is divided by 1,000 to calculate a rate that can be more easily compared.

Frequency: Reported quarterly, available approximately 5 months after end of the quarter.

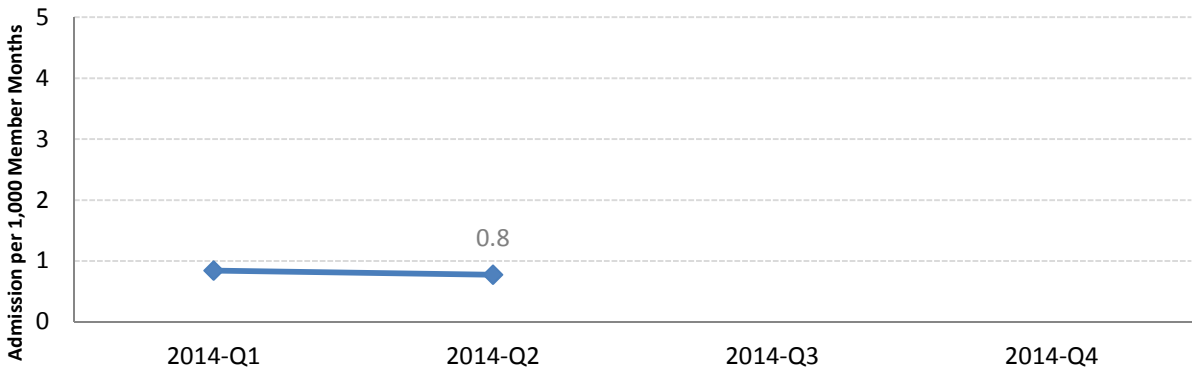
Figure 1-8: Inpatient Hospital Utilization Summary



Description: Measuring hospital admissions is a standard industry approach to better understand the use of acute (hospital) health services. This measure describes the number of admissions to a hospital, divided by the number of member months. The denominator is divided by 1,000 to calculate a rate that can be more easily compared.

Frequency: Reported quarterly, available approximately 5 months after end of the quarter.

Figure 1-9: Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members



Description: Ambulatory care sensitive admissions are conditions that can be impacted by the availability, use, and quality of ambulatory (office) care. A high or increasing number of admissions could indicate that members are having difficulty accessing primary care services. This measure describes the number of inpatient hospital admissions for ambulatory care sensitive conditions, divided by the number of member months. The ambulatory care sensitive conditions included in this measure are: asthma, dehydration, bacterial pneumonia, urinary tract infection, and gastroenteritis. The denominator is divided by 1,000 to calculate a rate that can be more easily compared.

Frequency: Reported quarterly, available approximately 5 months after end of the quarter.

Figure 1-10: All Cause Readmissions within 30 Days

(Available Summer 2015)

Description: Hospital readmissions can be an indication of avoidable difficulties transitioning from a hospital to the next care setting, either to another medical facility or home. A high or increasing number of readmissions could indicate that better discharge planning is needed. This measure describes the number of adult members who were readmitted to a hospital for any reason within 30 days of discharge, divided by the total number of members discharged from a hospital, as a percentage.

Frequency: Reported annually.

New Notable Results

- Member requests for assistance accessing providers have fallen slightly. Falling requests for assistance would be expected after members have become familiar with accessing health care services. (Figure 1-1)
- The member to provider ratio for pediatricians has fallen. This ratio indicates that a greater number of pediatricians are available for the number of children in a MCO. (Figure 1-2)
- The number of emergency department visits has increased slightly. The Department will continue to monitor this measure. (Figure 1-6)

New and Retired Measures

- Average Prescriptions per Member per Month was retired.

DOMAIN: Customer Experience of Care

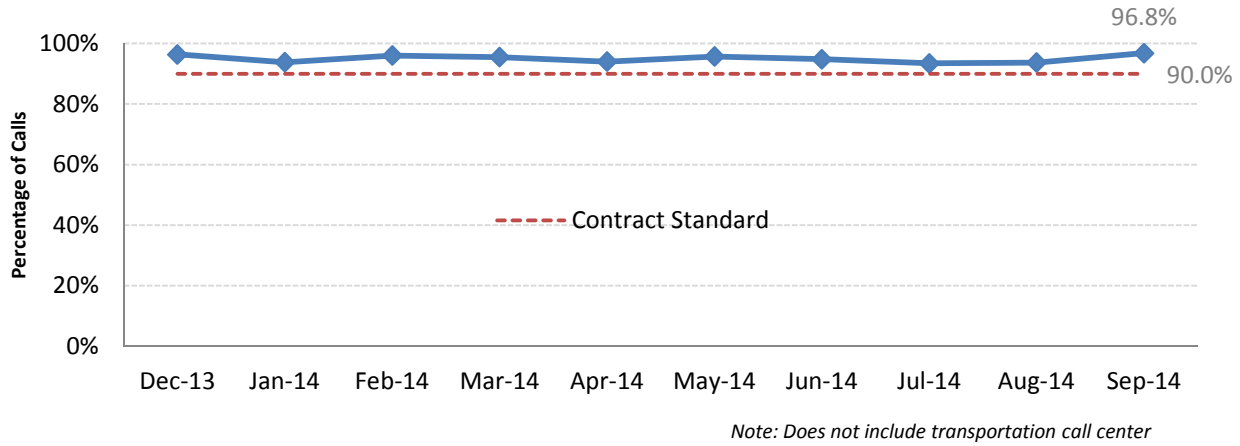
Introduction

Customer Experience of Care includes key indicators in the following areas:

- Member Call Center
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Member Call Center

Figure 2-1: Calls Answered in 30 Seconds

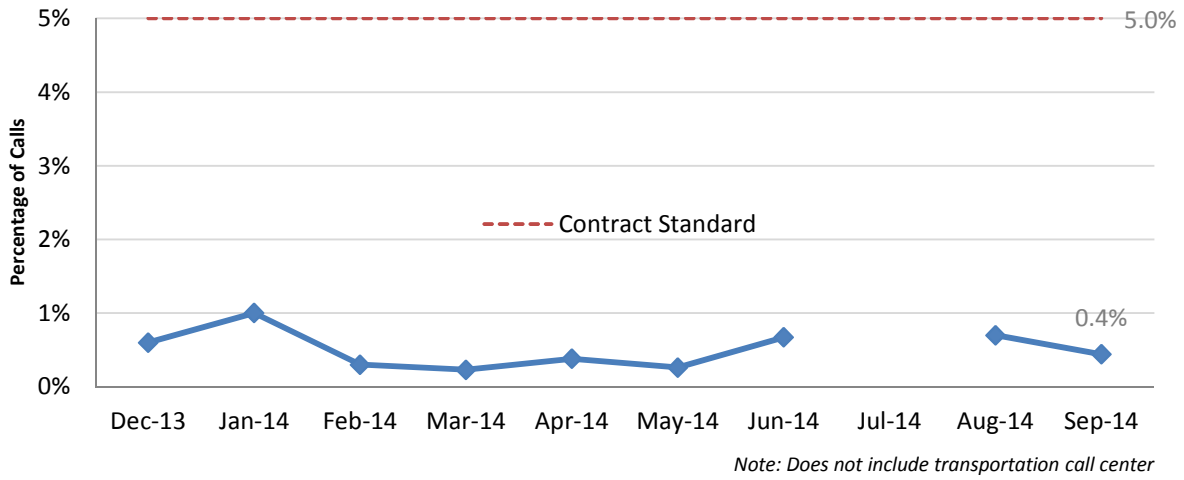


Note: Does not include transportation call center

Description: Answering incoming calls quickly is an important component of a good customer experience of care. A falling number of calls answered within 30 seconds could indicate problems within a call center. The MCM contract standard for this measure is 90%. This measure describes the number of calls from a member to their MCO that were answered within 30 seconds, divided by the number total number of calls, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

Figure 2-2: Member Communications: Calls Abandoned (NEW)



Note: Does not include transportation call center

Description: Minimizing the number of calls that are abandoned is an important component of customer experience of care. A rising percentage of calls abandoned could indicate problems within a call center. The MCM contract standard for this measure is less than 5% of calls are abandoned. This measure describes the number of calls from a member to their MCO that were abandoned, divided by the number total number of calls, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

Customer Satisfaction Survey

Annual CAHPS Report

(Available Winter 2014, then annually in summer starting in 2015)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standard national tool that measures member satisfaction with their health care. DHHS is performing a CAHPS survey to measure year one satisfaction with the MCM program with results available in the winter of 2014. The MCOs will administer the survey beginning January 2015 and each January thereafter, with results available the following summer.

The CAHPS survey provides statistically valid measurement of members' satisfaction and experience with care including these key areas:

- Member's overall rating of their own health,

- Satisfaction with health plan, personal doctor, specialist seen most often, and the health plan,
- Satisfaction with health plan customer service,
- Satisfaction with ability to access needed care, and
- Satisfaction with how well doctors communicate and shared decision making.

New Notable Results

- For the data being reported (see Data Notes), member calls are being answered quickly and within MCM contract standards. (Figure 2-1 and 2-2)
- Data Notes:
    - One MCO has incorrectly reported member call center data from their transportation vendor. After this data has been corrected, transportation call center data will be added back to this measure. (Figures 2-1, and 2-2)

New and Retired Measures

- Calls Abandoned was added. (Figure 2-2)
- Average Call Time was retired.

DOMAIN: Provider Service Experience

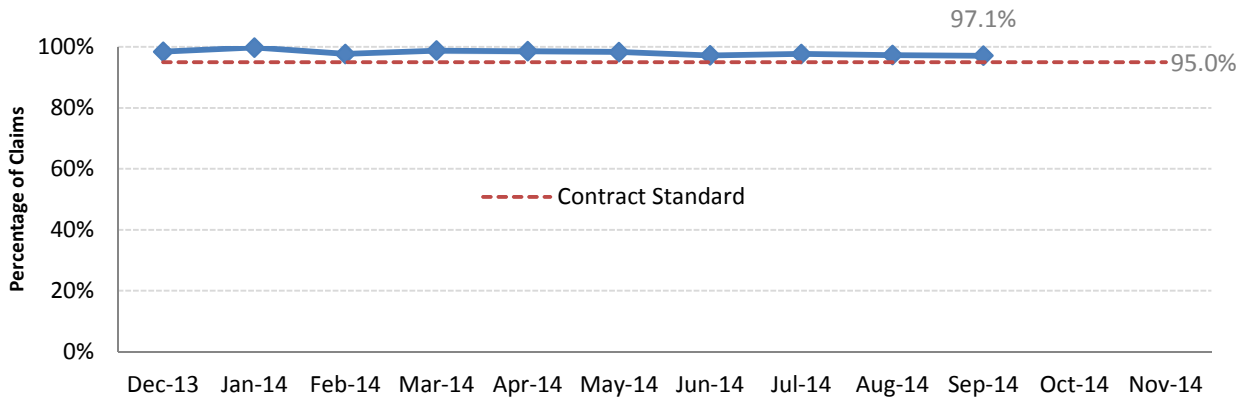
Introduction

Provider Service Experience includes key indicators in the following areas:

- Claims Processing
- Provider Call Center
- Provider Satisfaction Survey

Claims Processing

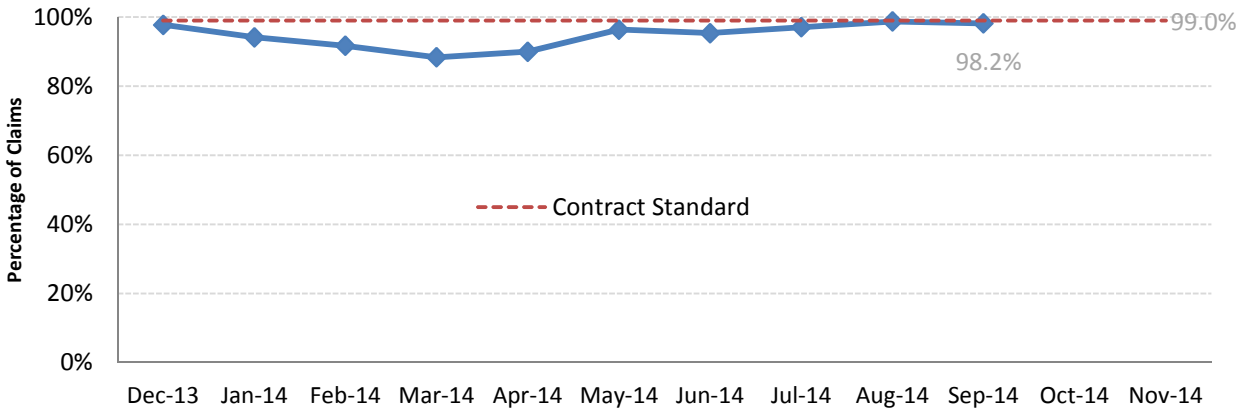
Figure 3-1: Professional and Facility Claims Processed in 30 Days



Description: Paying claims within 30 days is an important component of a good provider service experience. Claims must be "clean" of any inaccuracies in order to pay. A falling number of claims processed within 30 days could impact how quickly providers receive payment. The MCM contract standard for this measure is 95%. This measure describes the number of claims paid or denied in the month, divided by the number of claims received in the month, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

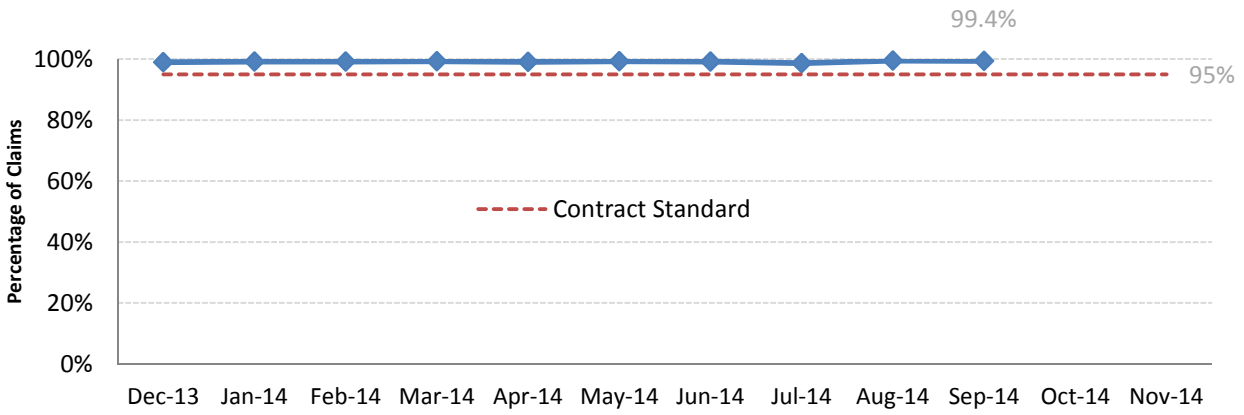
Figure 3-2: Pharmacy Claims Processed in Less than One Second



Description: Processing pharmacy claims in less than one second is an important part of a good pharmacist experience of service. The measure is a federal requirement for all Medicaid programs. The MCM contract standard for this measure is 99%. This measure describes the number of pharmacy claims accurately processed within one second as a paid or denied claim, divided by the total number of pharmacy claims, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

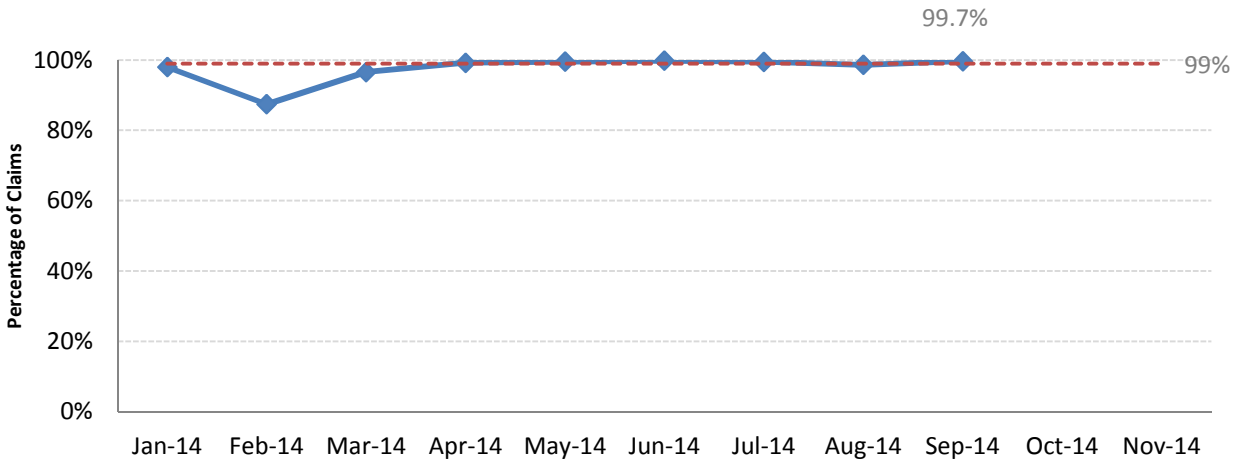
Figure 3-3: Claims Processing Accuracy



Description: Processing claims accurately is an important component of a good provider service experience. A falling number of claims processed accurately may indicate health plan system problems that need to be addressed. The MCM contract standard for this measure is 95%. This measure describes the number of claims correctly processed, divided by the total number of claims, from a sample of claims, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

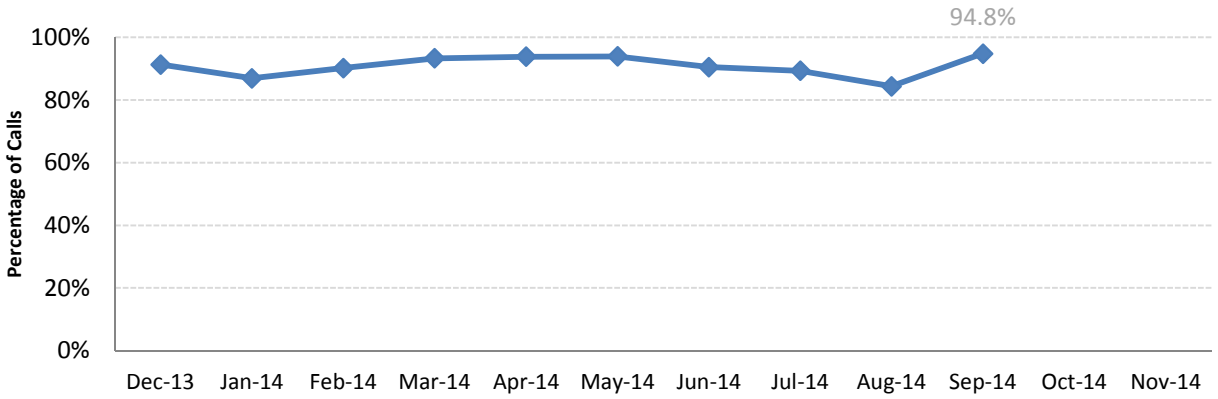
Figure 3-4: Claims Financial Accuracy (NEW)



Description: Paying claims accurately is an important component of a good provider service experience. A falling number of claims paid accurately may indicate health plan system problems that need to be addressed. The MCM contract standard for this measure is 99%. This measure describes the number of claims correctly paid or denied, divided by the total number of claims, from a sample of claims, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

Figure 3-5: Calls Answered in 30 Seconds

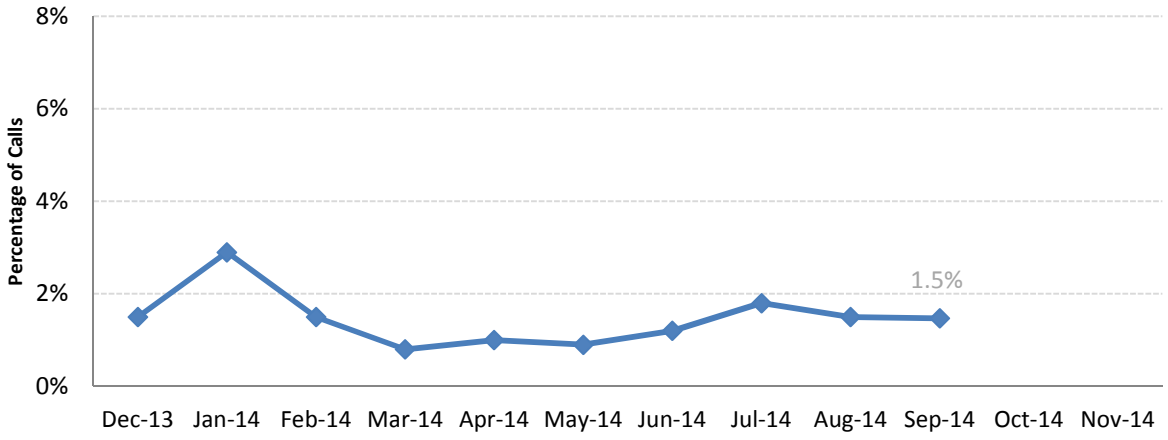


Note: Does not include transporation call center

Description: Answering incoming calls quickly is an important component of a good provider service experience. A falling number of calls answered within 30 seconds could indicate problems within a call center. This measure describes the number of calls from a provider to an MCO that were answered within 30 seconds, divided by the number total number of calls, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

Figure 3-6: Provider Communications: Calls Abandoned (NEW)



Note: Does not include transportation call center

Description: Minimizing the number of calls that are abandoned is an important component of a good provider service experience. A rising percentage of calls abandoned could indicate problems within a call center. This measure describes the number of calls from a provider to their MCO that were abandoned, divided by the number total number of calls, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

Provider Satisfaction Survey

Annual Provider Satisfaction Report

(Available Winter 2014)

Each MCO will conduct and produce an analytic narrative report that interprets the results from an annual provider satisfaction survey. This survey, administered by a third party, is based on a statistically valid sample of each major provider type: primary care providers, specialists, hospitals, pharmacies, durable medical equipment (DME) providers, and home health providers.

New Notable Results

- While provider clean claims are being paid, accurately and within MCM contract standards for timeliness, the Department is reviewing the MCO's billing manuals for clear and understandable directions and procedures for submitting claims. (Figure 3-1 through 3-4)
- Provider calls are being handled well. The percentage of provider calls answered in 30 seconds is increasing indicating that provider calls are being answered quickly. (Figure 3-5 and 3-6)
- Data Notes:
    - Figure 3-5, and 3-6: One MCO has incorrectly reported provider call center data from their transportation vendor. After this data has been corrected, transportation call center data will be added back to this measure.

New and Retired Measures

- Claims Financial Accuracy was added. (Figure 3-4)
- Calls Abandoned was added. (Figure 3-6)
- Average Call Time was retired.

DOMAIN: Utilization Management

Introduction

Utilization Management includes key indicators in the following areas:

- Service Authorization Processing
- Service Authorization Determination
- Pharmacy Utilization Management

Service Authorization Processing

Figure 4-1: Urgent Medical Service Authorization Processing Rate

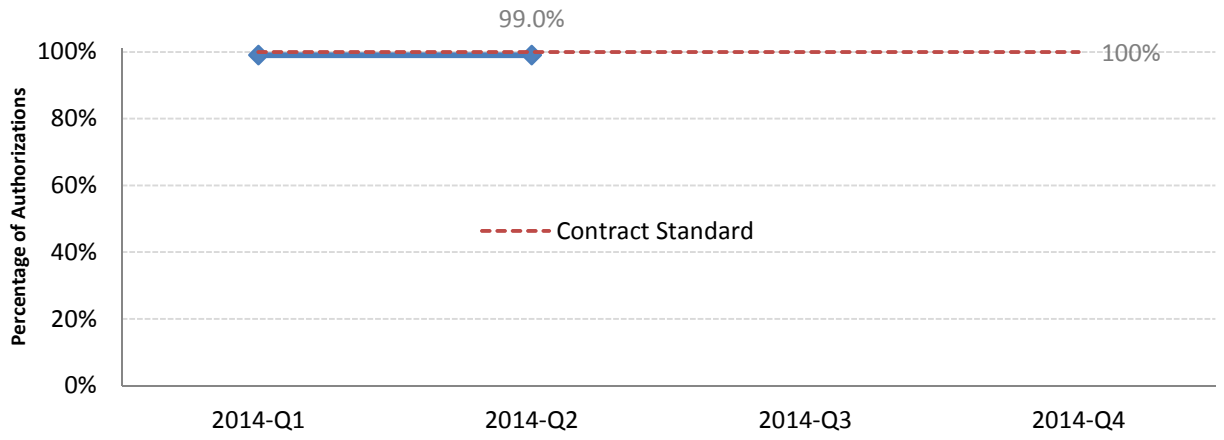


Chart unchanged from last month's report

Description: When medical services requiring prior authorization are needed quickly, an urgent service authorization decision must be made within 72 hours. Longer times for authorization may contribute to member difficulties getting needed or timely care. (Note: Emergency care does not require prior authorization.) The MCM contract standard for this measure is 100%. This measure describes the number of urgent authorizations, both approved and denied, divided by the total number of urgent authorization requests received, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Figure 4-2: Routine Medical Service Authorization Processing Rate

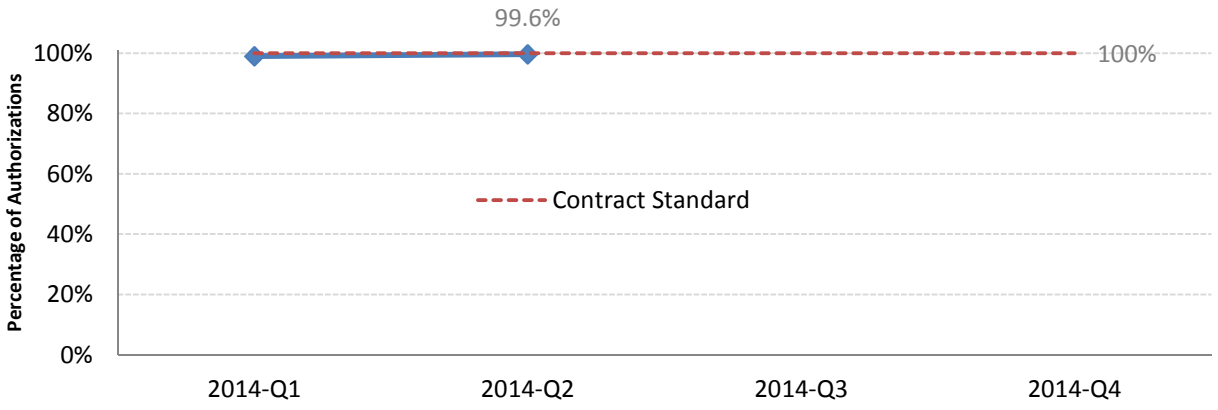


Chart unchanged from last month's report

Description: When routine medical services requiring prior authorization are needed, a service authorization decision must be made within 14 days. Longer times for authorization may contribute to member difficulties getting needed or timely care. The MCM contract standard for this measure is 100%. This measure describes the number of routine authorizations, both approved and denied, divided by the total number of routine authorization requests received, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Figure 4-3: Pharmacy Service Authorization Processing Rate

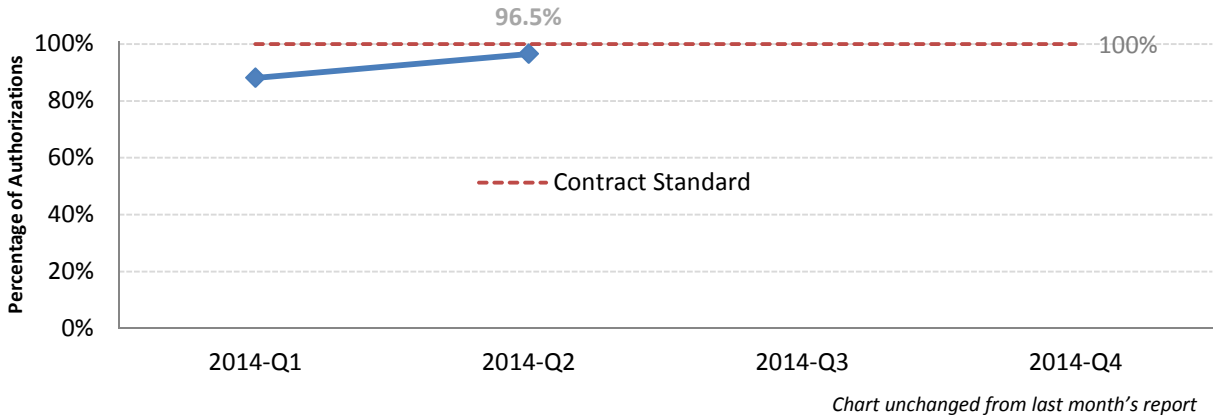


Chart unchanged from last month's report

Description: When pharmacy services requiring prior authorization are needed, a service authorization decision must be made within 24 hours. Longer times for authorization may contribute to member difficulties getting needed or timely care. This measure describes the number of pharmacy authorizations, both approved and denied, divided by the total number of pharmacy authorization requests received, as a percentage. The contract standard is 100%.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Service Authorization Determinations

Figure 4-4: Service Authorization Requests and Benefit Decisions by Type of Service

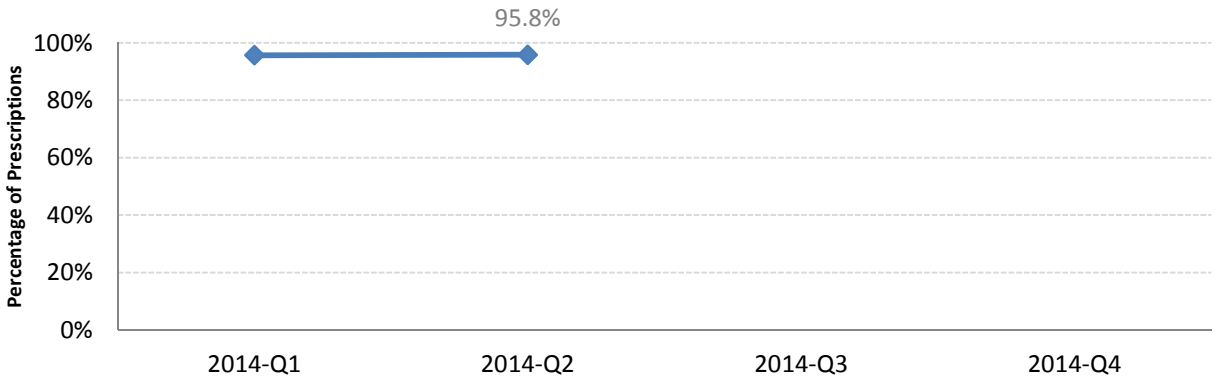
	2014 Q1			2014 Q2		
Average Membership	111,279			111,444		
	Requests	Approval Rate %	Denial Rate %	Requests	Approval Rate %	Denial Rate %
All Services	102,067	85.1	6.3	153,257	86.5	6.7
Selected Services						
PT/OT/ST	3,984	85.9	7.3	5,553	87.5	7.4
NEMT	21,887	98.6	1.3	37,448	99.1	0.4
Pharmacy	10,440	79.2	14.1	14,119	82.0	12.0
Physician/Medical Services	22,896	78.7	8.0	33,729	78.7	9.9
Private Duty Nursing	420	81.4	2.6	640	85.9	4.4
Personal Care Attendant	93	78.5	1.1	120	78.3	7.5

Table unchanged from last month's report

Description: Measuring the types and outcomes for health care service authorizations is a standard industry approach to better understand health care services utilization. The measure counts the total number of service authorizations received, approved and denied, by selected categories of service. It also includes the percent of service authorizations received, approved, and denied by all categories of service. Pending authorizations are not included so the approval and denial rate will not total 100% in this table.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Figure 4-5: Pharmacy Utilization Management: Generic Drug Substitution (NEW)



Description: Number of prescriptions filled for generic drugs during the measure data period, divided by the total number of generics and multi-source brand (drugs for which a generic is available) prescriptions filled during the measure data period, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

New Notable Results

- Urgent and routine service authorizations are being processed very close to MCM contract standards for timeliness. (Figures 4-1 and 4-2)
- The pharmacy service authorization processing rate continues to trend upward toward the contract standard. The Department will continue to monitor this indicator. (Figure 4-3)
- Generic drug substitution rate is very high and could contribute to program cost containment. (Figure 4-5)

New and Retired Measures

- Generic Drug Substitution was added. (Figure 4-5)
- Generic Drug Utilization Adjusted for Preferred Brands was retired.

DOMAIN: Grievances and Appeals

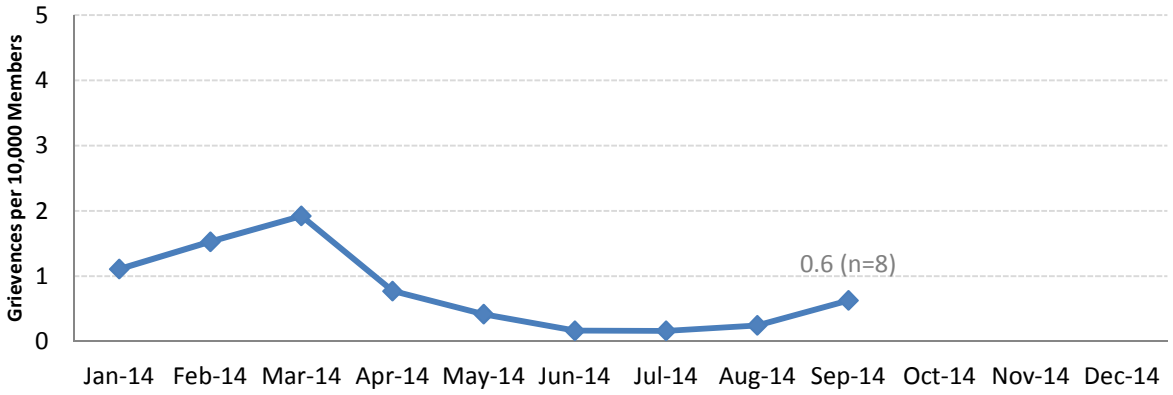
Introduction

Grievances and Appeals include key indicators in the following areas:

- Counts
- Processing Timeframes

Counts

Figure 5-1: Grievances



Description: Grievances are counted when a member contacts the health plan with a concern or complaint. An increasing number of grievances, or a single serious grievance, could indicate that additional health plan attention is needed. This measure counts the total number of grievances received. The rate is shown per 10,000 members. For example, a rate of 1 grievance would indicate that out of every 10,000 members there was 1 individual filing of a grievance.

Frequency: Reported monthly, available approximately 2 months after end of the month.

Figure 5-2: Number of Appeals

	2014 Q-1	2014 Q-2
All Services	**275**	**464**
Selected Services		
Inpatient Admissions	**15**	**7**
PT/OT/ST	**26**	**21**
NEMT	**0**	**5**
Pharmacy	**171**	**375**
Private Duty Nursing	**1**	**0**
Personal Care Attendant	**0**	**0**

Table unchanged from last month's report

Description: Measuring the number of service authorization appeals by type of health care service is a standard industry approach to better understand health care services utilization. A rising number of appeals could indicate difficulties with utilization management or access to health care services. This measure counts the total number of appeals received, by selected categories of service, and the total of all appeals received.

Frequency: Reported quarterly, available approximately 2 months after end of the quarter.

Processing Timeframes

Figure 5-3: Grievance Dispositions Made in 45 Calendar Days

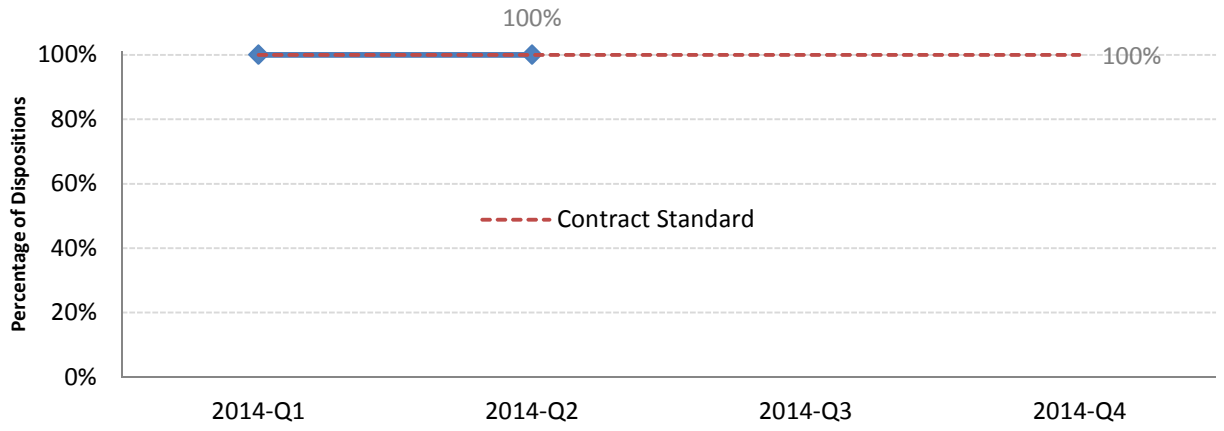


Chart unchanged from last month's report

Description: Resolving grievances within 45 days ensures that substantive problems are recognized and addressed by the health plan. A falling rate of grievances resolved within 45 days could contribute to difficulties for other members. The MCM contract standard for this measure is 100%. This measure counts the number of grievances resolved within 45 days, divided by the total number of grievances received, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Figure 5-4: Standard Appeals Resolved in 30 Calendar Days

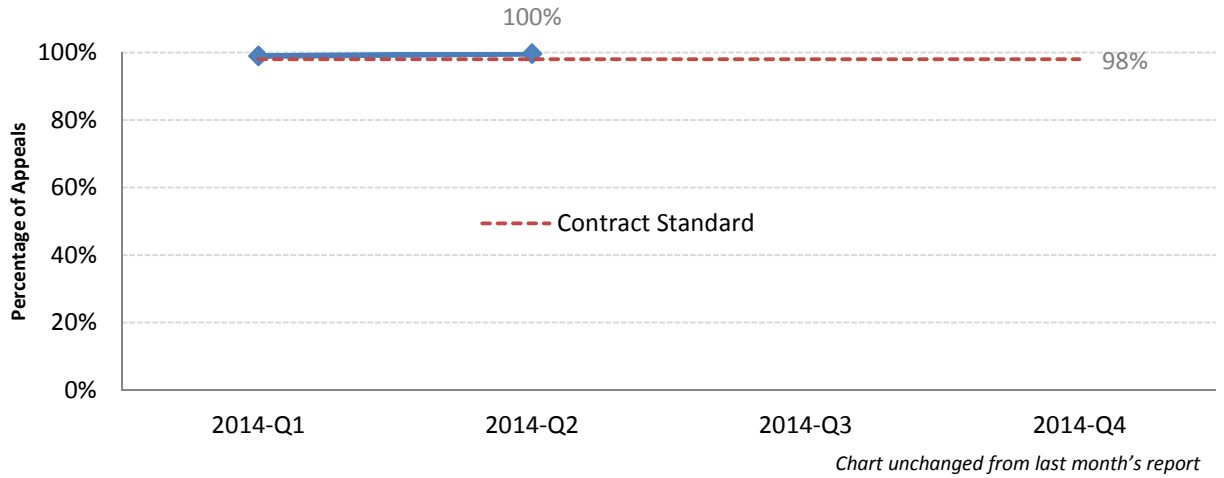


Chart unchanged from last month's report

Description: Standard appeals require a decision within 30 calendar days. Resolving appeals within 30 days ensures that needed health care services are not inordinately delayed. A falling rate of appeals resolved within 30 days could contribute to delays in needed health care for members. The contract standard for this measure is 98%. This measure counts the number of routine appeals resolved within 30 days, divided by the total number of appeals received, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Figure 5-5: Expedited Appeals Resolved in 3 Calendar Days

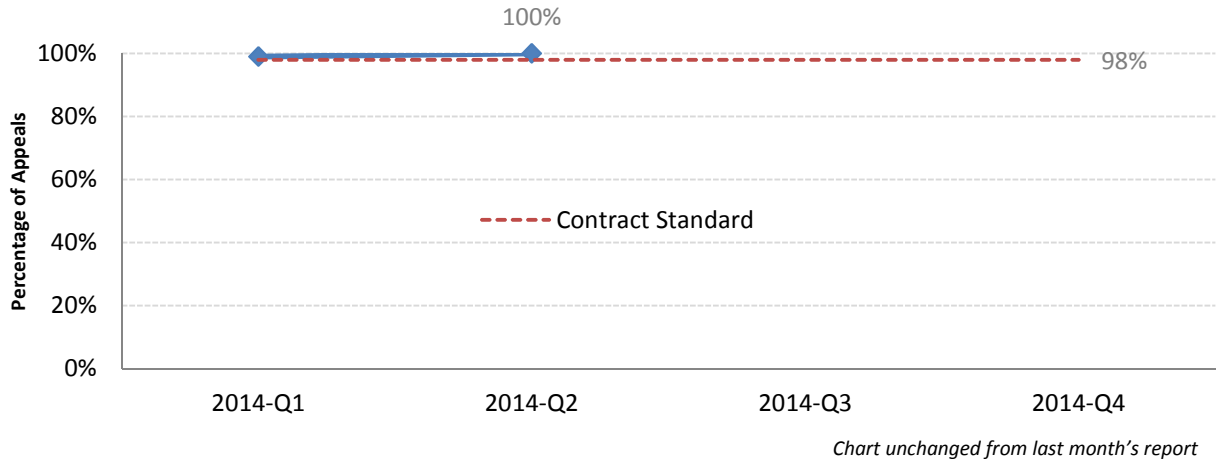


Chart unchanged from last month's report

Description: Expedited appeals require a decision within 3 calendar days. Resolving expedited appeals within 3 days ensures that needed health care services are not inordinately delayed. A falling rate of expedited appeals resolved within 3 days could contribute delays in needed health care for members. The contract standard for this measure is 100%. This measure counts the number of expedited appeals resolved, divided by the total number of expedited appeals received, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Figure 5-6: Appeals Elevated to State Fair Hearing

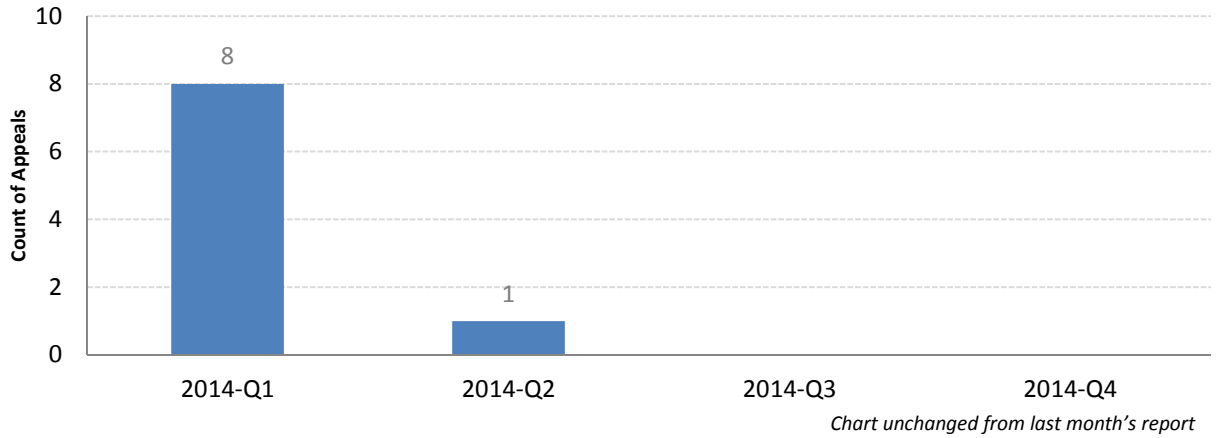


Chart unchanged from last month's report

Description: A member may file a request for a State Fair Hearing, if a member does not agree with the MCO's resolution of the appeal. Appeals elevated to State Fair Hearings are an indicator of member satisfaction with the MCO's decision. This measure counts the number of appeals that have elevated to a State Fair Hearing.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

New Notable Results

- The number of grievances has increased slightly. (Figure 5-1)
- Grievances and appeals (standard and expedited) are being resolved within MCM contract standards. (Figures 5-3 through 5-5)

DOMAIN: Preventive Care

Introduction

Preventive Care includes key indicators in the following areas:

- Prevention Assessment
- Healthcare Effectiveness Data and Information Set (HEDIS) Preventive Care Measures

Prevention Assessment

Figure 6-1: Health Risk Assessment Completed

(Available March 2015)

Description: Health risk assessments help a health plan understand what medical services a member may need. Health risk assessments are helpful in identifying and addressing gaps in preventive services. A low or falling number of health risk assessments completed could contribute to missed opportunities to provide preventive care. This measure counts the total number of health risk assessments completed.

Frequency: Reported quarterly, available approximately 2 months after end of the quarter.

Healthcare Effectiveness Data and Information Set (HEDIS) Preventive Care Measures

The Healthcare Effectiveness Data and Information Set (HEDIS) is a standard national tool to measure performance on important dimensions of care and service, including preventive care and services. Altogether, HEDIS consists of 81 measures across five domains of care. The results, available annually in the summer, allow an ability to monitor and conduct performance improvement activities related to health outcomes. The five domains of care are:

- Effectiveness of care
- Access and availability of care
- Experience of care
- Utilization and relative resource use
- Health plan board certification and membership overview

New Notable Results

Data is not yet available.

DOMAIN: Chronic Medical Care

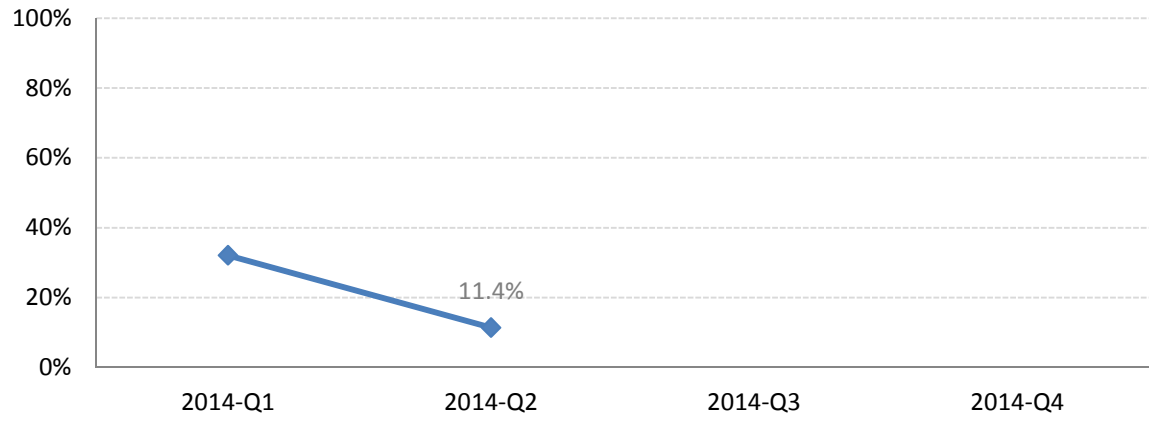
Introduction

Chronic Medical Care includes key indicators in the following areas:

- Pharmacy
- Healthcare Effectiveness Data and Information Set (HEDIS) Chronic Care Measures

Pharmacy

Figure 6-2: Maintenance Medication Gaps (NEW)



Description: Missing medication doses can contribute to poor health. A rising number of missed doses may indicate greater risk for adverse health outcomes. This measure describes the number of maintenance medications with gaps greater than 20 days between refills, divided by the number of members on maintenance medications, as a percentage. Maintenance medications are drugs that a member takes for longer than 120 days.

Frequency: Reported quarterly, available approximately 6 months after end of the quarter.

Figure 6-3: Polypharmacy Monitoring for All Medications

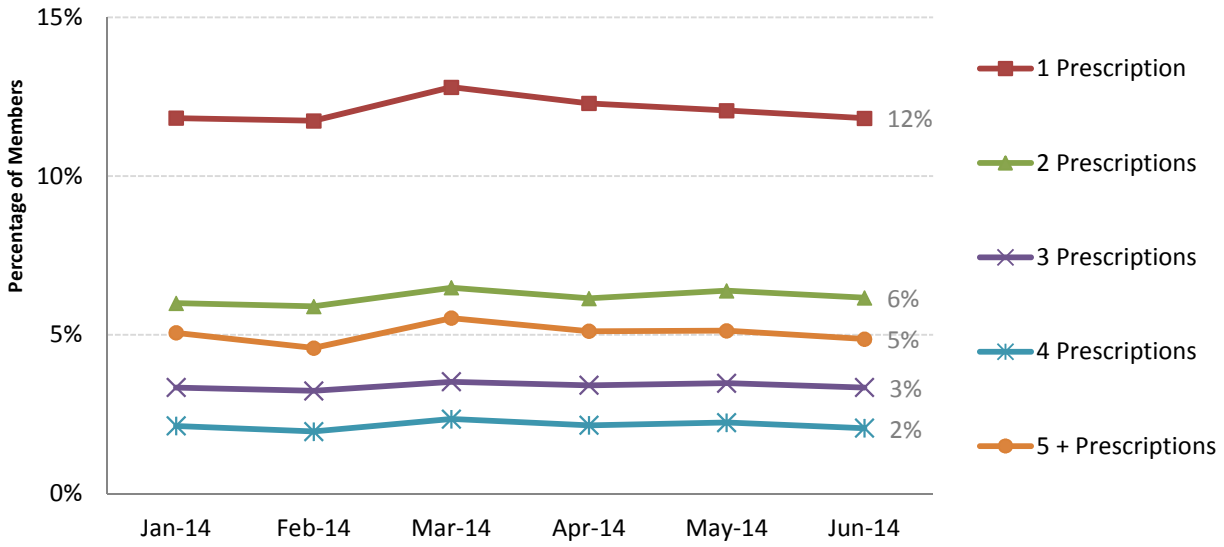


Chart unchanged from last month's report

Description: Medications can interact with each other and can contribute to poor health. Polypharmacy means that a member is taking multiple medications. Members on multiple medications can be at greater risk for adverse health outcomes. A rising or high number of members using multiple medications may indicate drug use review is needed. This measure describes the number of members taking multiple medications, divided by the number of members, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Healthcare Effectiveness Data and Information Set (HEDIS) Clinical Measures

The Healthcare Effectiveness Data and Information Set (HEDIS) is a standard national tool to measure performance on important dimensions of care and service, including preventive care and services. Altogether, HEDIS consists of 81 measures across five domains of care. The results, available annually in the summer, allow an ability to monitor and conduct performance improvement activities related to health outcomes. The five domains of care are:

- Effectiveness of care
- Access and availability of care
- Experience of care
- Utilization and relative resource use
- Health plan board certification and membership overview

New Notable Results

- Maintenance medication gaps are falling indicating a smaller number of prescriptions with long gaps between refills. Taking medications regularly by ensuring their availability should contribute to better chronic disease management. (Figure 6-2)

New and Retired Measures

- Maintenance Medication Gaps measure was added. (Figure 6-2)

DOMAIN: Behavioral Health Care

Introduction

Behavioral Health Care includes key indicators in the following areas:

- New Hampshire Hospital Discharges
- Behavioral Health Survey

New Hampshire Hospital Discharges

Figure 7-1: Members with Follow-up Appointment 7 Calendar Days Post Discharge

(Data is currently undergoing review and will be re-presented in January 2015)

Description: A follow appointment within 7 days of discharge from a New Hampshire Hospital can help ensure that a member continues to improve and stays well after discharge. A low or falling number of follow up appointments within 7 days could indicate that better discharge planning is needed. This measure describes the number of adult members who were discharged from New Hampshire Hospital and followed-up with a provider within 7 days of discharge, divided by the total number of members discharged from New Hampshire Hospital, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Figure 7-2: Readmission to New Hampshire Hospital at 30 days -Excluding New Hampshire Health Protection Program (NHHPP) Members

(Data is currently undergoing review and will be re-presented in January 2015)

Description: Hospital readmissions can be an indication of avoidable difficulties transitioning from a hospital to an outpatient care setting. A high or increasing number of readmissions could indicate that better discharge planning is needed. This measure describes the number of adult members who were readmitted to New Hampshire Hospital within 30 days, divided by the total number of members discharged from New Hampshire Hospital, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Behavioral Health Survey

Annual Behavioral Health Annual Survey

(Available Summer 2015)

Description: This narrative report will describe results from a consumer satisfaction survey from members with behavioral health conditions. Substance Abuse and Mental Health Services Administration (SAMHSA) tools and methodology will be used.

Frequency: Collected annually and available approximately in August.

New Notable Results

- None.

DOMAIN: Substance Use Disorder Care

Introduction

Substance use disorder (SUD) services will be initiated in phases with the start of the New Hampshire Health Protection Program (NHHPP). When implemented, Substance Use Disorder Care will include key indicators in the following areas:

- Rate of Substance Use Disorder Service Users and Utilization in NHHPP Population
- Use of the ED for SUD conditions in NHHPP and Existing Medicaid Population

Substance Use Disorder Services Users and Utilization

- Overall Rate of Any SUD Service
- Outpatient Counseling
- Medically Monitored Withdrawal
- Opioid Treatment Center
- Use of Buprenorphine
- Partial Hospitalization
- Intensive Outpatient Treatment
- Inpatient Withdrawal
- Rehabilitation
- Mobile Crisis Intervention
- Office Based Crisis Intervention

(Measures available beginning June 2015)

Use of the ED for SUD in the NHHPP and Existing Medicaid Population

(Available June 2015)

New Notable Results

Data is not yet available.

DOMAIN: General

Introduction

The General domain includes key indicators in the following area:

- External Quality Review Organization (EQRO) Technical Report

External Quality Review Organization Technical Report

Annual Report: EQRO Technical Report (NEW)

Description: An External Quality Review Organization is an independent entity ensuring compliance with federal and state regulations and quality outcomes. HSAG, Inc. is the EQRO for the New Hampshire MCM program. The EQRO Technical report is an annual detailed report describing MCO data aggregation and analysis and the way in which MCO conclusions were drawn regarding the timeliness, quality, and access to care furnished by the managed care organization.

Frequency: Annual in November.

New Notable Results

- The 2014 EQRO Technical Report is available and can be downloaded from: http://www.dhhs.state.nh.us/ombp/quality/documents/eqro-tech-rpt.pdf

Appendix A

Acronym List

APRN	Advanced Practice Registered Nurse
CAHPS	Consumer Assessment of Healthcare Providers and Systems; a national consumer satisfaction survey
DME	Durable Medical Equipment;
EQR	External Quality Review
EQRO	External Quality Review Organization; the State of New Hampshire's current EQRO is HSAG, Inc.
HEDIS	Healthcare Effectiveness Data and Information Set; a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance
MCM	Medicaid Care Management
MCO	Managed Care Organization
NEMT	Non-Emergency Medical Transportation
Q1	Quarter 1: January 1 – March 31
Q2	Quarter 2: April 1 – June 30
Q3	Quarter 3: July 1 – September 30
Q4	Quarter 4: October 1 – December 31
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance Use Disorder